

Collaborating Oral Health into the Medical Home

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Sponsored by the Idaho Oral Health Alliance

Dr Richard Rysdam, Regional Medical Officer for HRSA, kicked off the program explaining Health and Human Services initiatives in oral health. The HHS realized that their agency needed to make oral health a higher priority as oral disease continues to be costly – tied with cardiovascular disease and second to cancer as the most expensive health care costs. Also, oral diseases are recognized as risk factors for a number of systemic conditions and are concentrated in the populations served by government programs. He pointed out the HRSA's Strategic Plan is to:

- Improve Access to Quality Health Care and services
- Assure a Medical Home for the populations served
- Expand Oral Health and Behavioral Health into the primary care setting

Dr. Russell Meier, MD, Asst. Prof. Family Medical Residency Program, followed with a discussion on Washington State's efforts to integrate oral health into the primary care setting. Why primary care? Oral diseases are preventable; good evidence that primary care intervention can make a difference; children and underserved population have better medical access than dental. This is important because 80% of oral diseases are in 25% of the population, which are the underserved. Plus, only 36% of children 2- y/o has had a dental visit in the last year. The mouth is part of the body, so it cannot be ignored during a primary care exam and by age two, children have probably seen their primary care provider 8 times.

University of Washington Department of Pediatric and Family Medicine conducted a pilot program in Yakima, Washington and developed a curriculum to teach primary care providers eight annotated training modules. It worked and was readily accepted by providers. The broad impact it take there have been 107,000 downloads of the course since 2005 and is core curriculum in 30 medical schools and taught in most family practice medical programs. Washington also initiated an ACCESS TO BABY AND CHILD DENTISTRY program that has trained 650 dentists to be more comfortable seeing young children for preventive treatment. This has increased the utilization of under 6 Medicaid visits 19-36% from 1994 to 2005, and 13% of children under 2 in 2004. Dr. Meier pointed out the barriers to the program were – National and local politics, lack of service codes, insurance, medical, health and dental silos, financing and infrastructure.

Mimi Hartmann-Cunningham, Idaho Oral Health Program Manager, announced Idaho had received a DentaQuest Foundation grant award of \$100,000.00. She explained that the essence of the award was to establish the infrastructure to bring closer medical and dental collaboration.

Dr. Charlotte Lewis, M.D., Professor, University of Washington School of Medicine presented her research on oral health and pediatric practice. She emphasized that we share the overarching common belief that “Oral health is integral to overall health, and therefore, oral health care is an essential component of comprehensive health care”. A survey of pediatricians revealed that they believed oral health was within their purview, but had little oral health education, and although they routinely saw oral health problems, it was difficult to find dental care for some children. Only 15% agreed in dental visits for one year olds and few had heard of fluoride varnish. Washington was the only state that offered training to Primary Care Physicians (PCPs) and offered Medicaid to PCPs for fluoride varnish. At first, PCPs felt too overwhelmed to add oral health education and assessment to their child visits, but soon learned that it did not require a burdensome amount of time and they could provide oral health education and their staff apply the fluoride varnish. Main problem was finding dental referrals – the key was Medical and Dental collaboration. She noted that a model where dentists are co-locating with PCPs, evidenced in Community Health Centers.

Then the American Academy of Pediatrics (AAP) added oral health to its strategic plan. The Chapter of Oral Health Advocates (COHA) was formed and initiated training modules, which included, importance of oral health in primary care; basic oral health and cariology, oral health risk assessment, prevention and anticipatory guidance, screening oral exam, reimbursement for services, and referral to dental professionals. A committee of pediatricians, pediatric dentists, general dentists, AAP and ADA representatives developed the training module and 73 advocates were recruited for training from 56 AAP chapters. Lessons learned pointed out different challenges, but mainly colleagues worried about effect of patient flow and hard to change their thinking. They agreed that we need a paradigm shift in how we value preventive oral health- we need a shared mission. The concept of medical and dental home promotes a collaborative role with MD’s providing oral health care and education for the first 2 to 3 years with emphasis on primary and secondary prevention; identify high risk children and collaborate with dental professionals.

Health and Human Services has also made oral health a high priority. They requested an “action plan report” from the Institute of Medicine. Their report highlighted “elimination of barriers, including political and social, prioritizing disease, rely on expanded, multidisciplinary providers in a variety of settings, collaboration, and foster continuous improvement and innovation”. Audience questions focused on reimbursement.

Dr. Jay Anderson, DDS, MHS, Director of Practice Improvement, DentaQuest Institute and former Chief Dental Officer for HRSA, presented on “When Two Becomes One: Effective Model for Medical-Dental Integration. Early Childhood Caries Project – risk management and assessment on children. Noted that 1/3 of children waiting for O.R. (6 to 12 months) were maintained with fluoride varnish applications. Components of an Ideal Oral Health System – fully integrated into primary health care system emphasizing health promotion/disease prevention; monitors population oral health status, evidence-

based, effective, efficient, sustainable, equitable, universal, comprehensive, ethical, offers, QA, CQI, and cultural competency. Why integration? Oral Diseases and medical health conditions are interrelated. Oral Health access is enhanced when provided in primary care settings; Oral health prevention and Disease Management is cost effective when provided in primary care settings: outcomes for children receiving preventive and disease management protocols in primary care settings are effective. Barriers include separate education, licensing, regulation and practice for medical and dental professionals and non-integrated benefits/insurance programs. Medicine has historically divorced itself from oral diseases and never built time into the provider visit for oral management. Given the value of integration, we need to overcome the barriers as well as create healthy health status we can measure.

Irene Hilton, DDS, MPH, Dental Consultant, National Network for Oral Health Access (NNOHA) presented on “NNOHA’s Role in Integrating Oral Health into Medical Homes”. Dr. Hilton began by explaining how NNOHA is an organization representing community health/safety-net dental programs consisting of over 1,700 members. In a cooperative agreement with NNOHA, HRSA has promoted the Patient Centered Medical Home (PCMH), which integrates medical, pharmacy, behavioral health, and dental care within one health center. In order to begin developing PCMHs, an online assessment of 77 out of 270 health center dental directors was conducted. From this assessment, several barriers to medical-dental integration were revealed as well as characteristics of health centers that have achieved successful integration. The criteria for providers who took the assessment were: current patient medication and problem lists were available to dental providers, dental appointments were able to be scheduled with other providers by the health center clinical staff, an oral health measure was incorporated into the Health Center Diabetes, HIV or Prevention collaborative, the percent of perinatal patients who received a dental exam was determined and reported, strategic planning included dental leadership participation, and lastly, specific policies and procedures existed for referral tracking and follow-up of diabetic patients into dental care, dental patients into behavioral health care, and dental patients with abnormal BP readings. An Early Childhood Caries (ECC) assessment was also incorporated into well-child visits for ages 0-5.

Assessment results indicated 55.8% of dental providers “routinely” have access to a patient’s medication and problem list, 51.9% participated in strategic planning for the organization, health center staff were able to schedule dental appointments with other providers 48.7% of the time, 44.0% included an oral health measure in the Health Center Diabetes, HIV, or Prevention collaborative, 41.6% of the time an ECC assessment was included in a well-child visit, and 38.2% of the time policies or procedures for follow-up on dental patients with abnormal BP readings were in place. One of the definite barriers to medical-dental integration was the incompatibility of oral health and other health care IT systems. Follow-up interviews were conducted on the nine highest performing dental programs, and from these seven key characteristics emerged. The seven characteristics begin with leadership vision and support, dental integrated into the health centers executive team, medical-dental services co-located, organizational culture of quality improvement, dental staff understand the importance, patient enabling services, and dental director leadership. Several best practices categorized in the six components of the Chronic Care Model were also established. Some examples of these include generating lists of children, perinatal, diabetics, and HIV patients who have not been referred for a dental exam, having dental

education brochures available in the waiting rooms of medical clinics, allowing call center staff to see and have access to both medical and dental scheduling, and health center staff compensation based on patient outcomes. Dr. Hilton proposed various next steps occur and some of these include continuing to identify best practices as well as developing a core curriculum on integrating oral health and medical care services.

Dan Watt, DDS, Dental Director, Terry Reilly Health Services, concluded our fall meeting his presentation on “Possible Methods for Integrating Oral Health Into the Medical Home”. Dr. Watt began by stressing the importance of building an effective infrastructure that meets the oral health needs of all Americans with the integration of oral and overall health. It is critical that perceptions be changed and a new national oral health strategy be developed. Several changes have already occurred in the public health sector, but progression still needs to occur, especially with dental disease being tied with heart disease as the 2nd most expensive. Dr. Watt proposed various changes that need to occur and include ideas such as developing an Oral Health Coordinator. This position would help to encourage better home care by identifying disease risks and developing protocols to eliminate them. Some of the barriers to integrating oral health into the medical home were identified as being the acceptance of organized dentistry and not having proper diagnosis codes or effective risk assessment tools. Lastly, mid-level providers still have yet to be defined and we are lacking political support for these positions. It is also important for dentistry to develop diagnostic tools similar to those used in medicine. We have several existing tools for managing oral disease risk, but none are diagnostic. Dr. Watt concluded his presentation by describing a possible method of oral health integration in the medical home by having a primary care physician supervise a specially trained oral health technician, the oral health coordinator, in managing oral disease.